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AUTHOR Adams, J. Winstead
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ABSTRACT

The drug abuser presents many difficult clinical problems to the conscientious therapist. Many of the prerequisites to human relationships associated with responsible, satisfying living are difficult to develop and must be nurtured in such a person. The author presents a philosophy of psychotherapy to serve as a guideline for therapists working with individuals who abuse drugs. An alternative to drug taking and the style of life that goes with it must be offered by the philosophy of thearpy. In such a philosophy there are six basic imperatives which are discussed and described. (Author)

J. Winstead Adams, M.S.W., Ph.D (Cand.)
Clinical Instructor in Psyc
Dept. of Psychiatry and Human
Associate Director - Jefferson Hospital Day Treatment Drug Program

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A PHILOSOPHY OF "PSYCHOTHERAPY" WITH THE DRUG DEPENDENT PERSON: SIX BASIC IMPERATIVES

Before one is able to talk about psychotherapy with the drug dependent person in more than general terms, it is necessary that the ambitious therapist have some kind of operational definition of who the drug dependent person is and how he views help at the time he is seen for treatment. To begin with he is someone who has taken some chemical substance into his system by shooting it into his veins, swallowing it, snorting it, smoking it and any or all combinations of these methods of getting drugs into his system, and he has done this for a period of weeks to a period of years. Not only has this person become psychologically dependent on the drug but if he has been using heroin, methadone or any of the barbiturates as the preferred drug of abuse, his body needs it to maintain its metabolic and psysiologic homeostatis. To abruptly discontinue its use under those circumstances would probably mean severe physical distress, and in the case of barbiturates the onset of convulsions and death. In other words to keep him functioning that person's body has developed a tolerance for doses of drugs which would be lethal to all non-drug dependent persons.

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I am also talking about someone who has undergone a departure,

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often times a radical departure, from his life style and its value system prior to his involvement with drugs. In order to maintain his habit he has lied, cheated, conned, stolen from friends and family, hustled his body heterosexually and homosexually, and if in dire need and in danger of the onset of his "Jones" (withdrawal symptoms) he may have committed crimes of violence against others, purse snatching, muggings, highway robbery, assault and battery, etc.

Further this person has probably himself faced death through an accidental drug overdose one to a dozen times; or helplessly ravaged by his habit, and at its mercy, unable to see a different future for himself, he may have deliberately injected himself with an overdose; or he may have been in the company of someone else who did in fact die from an overdose and he may have let that person die because the priority to him was his getting his fix.

So when he appears at your office or clinic or hospital or drug program, he says he wants help. And he is likeable and charming, a great many drug addicts and drug dependent people really are, and they have learned how to use their charm, and he really does at that moment in his terms want help. The problem is that despite his being able to mouth all the right words about how and in what way he needs help and needs to change, at rock bottom his concept of help is very different from yours. He may or may not know consciously that he wants to get involved in some drug program in order to buy time to get his habit down so it will be less expensive, or to satisfy the conditions of his probation, or to get his parents off of his back, or to deal dope. He may even honestly believe

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(it when he says that he is tired of the life he has been living and wants to clean up and change his life's direction. But what anybody working with or who anticipates working with drug dependent people - from the hard core heroin user to the upper middle class speed freak - has to know is that at base, at the very center of the person at the time when they make that initial request for help to get off drugs, they have not given up hope of some day sooner or later getting high again, the unconscious fantasy being (and often not so unconscious) that at a later date they can handle drugs more responsibly. It is similar to the fantasy of many non-drinking or recovered alcoholics that one day they will learn to become a social drinker. And when one stops to think about it rationally, the idea of getting high can be appreciated. Not only is it an effective temporary escape from the ugliness of ones reality if one lives in a rat and roach infested ghetto, and an effective means of buoying up and enchancing ones feelings about ones self creating a sense of more confidence and increased self esteem if these are personality deficits, but getting high is also very pleasant. It just plain feels good. And if the drug taker has taken drugs for so long that they have become an effective substitute for him for his less effective psychological and emotional coping mechanisms, or if the drug taker began taking drugs at a time in his life during his vulnerable adolescent years thereby disallowing the development and strengthening of his inner resources and defenses, and therefore can barely depend on anything but drugs, then what are the viable alternatives?

Traditional psychotherapy by its very process promotes stress and relies on the mobilization of anxiety to produce change. This in itself

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is contrary to the dynamics of the addict. His goals are to run from stress, and he has not developed the ability to tolerate anxiety much less to convert it into a positive life force for himself. So obviously I am not talking about the concept of traditional psychoanalytically oriented psychotherapy in the practice of which the therapist relies maninly on the technique of interpretation to aid the patient in gaining insight into unconcious mental phenomena, although with some drug dependent persons these principles do have a legitimate place in the treatment process. But in the beginning of treatment and very often throughout, therapy needs to be approached from the point of view of a different mental health model. Working with the drug dependent person - and that is how it should be conceptualized by the way, working with and not treatment of - inworking with the drug dependent person I don't view therapy as being as much of a process at it is rather a philosophy.

I have indicated that Psychotherapy with the Drug Dependent Person must offer a viable alternative to drug taking, which means that psychotherapy must provide an alternative to a style of life. Drug dependent people, especially young people who are actively into drugs, form a very special sub-culture. Without going into the political and idealogical tenets of that sub-culture, suffice it to say that, it provides them with something to do, an occupation, an identity and a status. The complaint and, therefore, the resistance that the older addict and the younger drug dependent person have to the notion of giving up drugs is "if I did, what would I do and what would I be". So, an alternative to drug taking and the style of life that goes with it must be offered by and built into a philosophy of therapy in working with the drug dependent

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person. Inherent in such a philosophy are what I term Six Basic Imperatives: Therapy must be 1. Confrontive, 2. Prohibitive, 3. Active, 4. Relative, 5. Repairative and 6. Manipulative.

CONFRONTIVE

Being Therapeutically confrontive in Group Psychotherapy often means different things to different people. To some therapists it is an upper modulation of the voice - yelling and screaming at someone else - getting out anger, etc. Although loud voices accompanied by pointing accusatory fingers have a place, it is methodological - a technique of contrived drama. Viewed as such, it can be used quite effectively by those who have the personality to make it appear real in conveying to the highly manipulative and constantly testing addict that the therapist can scream louder than the addict and is, therefore, in the addict's perception stronger than he. Many drug dependent people need to know that the therapist is capable of setting limits and controls and that he is strong enough to be trusted with his dependency on the therapist. To many addicts this must happen before he will share with the therapist and the group those things which are at the very center of him, his fragility, fear, anger, hurt, and loneliness, his vulnerability and his craziness. There are occasions when the therapist must literally overpower the personality of the addict with his own personality, however this is not what is meant by being confrontive in therapy.

Let me say what it is, it is the confrontation of faulty character defenses. Usually the drug dependent person has erected a whole network of character defenses even before his involvement in drugs, which have

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been re-inforced and amplified upon due to the need for survival in the drug sub-culture. These character defenses are numerous and range from insincerity to ruthlessness, from passivity to verbal grandiosity, from chameleon adaptiveness to near psychotic withdrawal. Such defenses must be confronted in therapy if the drug dependent person is to confront them in himself and begin to experience more honest interpersonal relationships, but they must be confronted within the emotional context of the therapeutic relationship.

The essence or "the soul" of any therapy is the relationship between the therapist and the person seeking help. It is the relationship which largely determines the direction in which therapy develops, whether it is talked about in terms of transference - counter transference, or the flow of positive - negative feelings, or love - hate feelings or ambivalences existing between therapist and patient. Generally, the feelings and defenses of the common everyday garden variety neurotic are used in the service of developing the transference or the therapeutic relationship in such a way that therapy proceeds. But, the drug dependent person enters into therapy with an entirely different "set". His previous intimate relationships have been based on dishonesty, trickery, scheming and connivance. What he gives of himself, he expects in return. His "trust factor" is indeed very low on the transaction scale of human relationships. The drug dependent person's feelings and defenses are used by him, consciously and unconsciously, to block the formation of a relationship which may lay the groundwork upon which therapeutic endeavors can be based. These are the defenses which keep the drug dependent person

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encapsulated and insulated, cut off from his feelings of affection, tenderness, compassion, sympathy, love, anger, etc., and therefore, remote, removed and estranged from the humanness of others. These are the defenses which must come under confrontation thereby exposing the drug dependent person to his own humanness. But these defenses cannot be confronted directly vis a vis interpretation, challenging or pointing out because the addict has not arrived at a point in his emotional and maturational development where he can benefit by such an approach. Such an approach will be felt as an assault upon the ego and will serve one of three purposes. 1. strengthening the defense, 2. having no effect at all, and 3. in the case of borderline patients,precipatating aggression towards others, towards the self or psychosis.

With the great majority of drug addicts we are dealing with psychopathy; i.e. impaired super-ego functioning and virtually no observing ego. We are also dealing with individuals who suffer from narcissistic disorders. For the group therapist this means that if he is going to be successfully used as a vehicle for change, he must in someway appear to his patients as being like them, or like that part of themselves to which the need for change is directed. In other words for the therapist working with the patient in that category of pathology just described, in order to be received by the patient in a way that will promote change, the therapist must align himself with that very pathology. By so doing, the therapist, by the skillful use of the appropriate techniques (which time does not permit discussion of here) is then able to move the addict to confront his own pathological defenses as they appear in the person of

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the therapist.

A brief example will demonstrate:

A sexually mixed addict group early in treatment was discussing their need for self protection in the street. The majority of them admitted to carrying weapons of some kind, guns, knives, ice-picks etc., with only two members having a dissenting opinion as to this type of need for self protection; one of the dissenters feeling that a real man - "a dude with balls" could take care of himself with out "heat" (gun). Rather than interpret this material as being in someway related to their deep sense of weakness,inadequacy, or fear of the hostile world, the therapist "joined" the pathological defense and told the group that he too felt it was a good idea for them to protect themselves by carrying a weapon. As a matter of fact that living the life they choose to live, they ought to at least carry two guns whenever they stepped foot outside. The therapist further offered that he had information about a local pawn shop where they could get under the counter "heat" cheap with no questions asked. Except for a few "right on's" and raised clenched fists, the sign for unity, and some raised eyebrows, there was no particular reaction to this statement.

For the next 5 or 6 sessions the therapist used every opportunity to "join" and align himself with the groups criminal and anti-social attitudes. Once even taking the inititive in ridiculing a group member who recently had been caught while burglarizing a physicians office for drugs, telling him that he wasn't even a good thief and instructing him

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as to how he could have successfully gone about it. At the following days session this same member attacked the therapist, saying that the therapist wasn't doing his job. That he was instead encouraging them to be "dope fiends" and criminals and was not helping them. Other members of the group responded that they had been feeling the same way and wondered where the therapist was coming from. The therapist asked for more information as to what he was doing that was wrong and what was it that he should be doing. Various members then began to respond and to tell the therapist what he should have said to themselves or to some other group member to be more helpful instead of what he did say. One angry member told the group that if they listened to the therapist much longer they were all going to wind up in jail, so they had better listen to himself instead.

As the group attacked and confronted their own pathological defenses and attitudes in the person of the therapist, they could then move to defining what their needs were. As they gradually did this, the therapist just as gradually shifted his position to correspondingly meet their own expressed needs to move in the direction of maturation and positive change. In this way the therapist was also building super-ego into the group rather than himself existing as the super-ego.

PROHIBITIVE

The next imperative that needs to characterize a philosophy of therapy is that it must be prohibitive. Put simply, certain behaviors need to be prohibited from the outset. Obiviously, the first prohibition

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is drug taking. It is foolhardy for the therapist to think that he can work in therapy with someone who is high on drugs. Under such conditions the individuals mood and affect are altered to an extent that mitigates against forming a real therapeutic alliance with the therapist and other group members.

In the group we are attempting to develop a network of meaningful communication. The group provides the addict with the opportunity to learn how to match their feelings and thoughts with the words that express them. They begin to do this by learning how to find the words which accurately express what they think and how they feel about others and about themselves within the arena of the group. Therefore certain materials and content must be prohibited from becoming a part of therapy sessions. Except in the initial stages of the therapy group when cohesion must develop, "needle and pill stories" are of little therapeutic value and in fact, can play subterfuge with the purpose and the goals of therapy. It is not uncommon in group therapy for one person to literally "turn on" other members of the group and himself by recounting fascinating exploits of drug taking and related episodes. The story teller and the listeners who associate their own experiences with what is being stated often receive a vicarious "high" or "rush" which is real and very akin to the affect of a drug experience. Having been exposed to this kind of "verbal tripping" in a therapy group, drug addicts who have been clean for months have been known to leave the session in search of the nearest "cop man" (drug supplier) in order to shoot dope.

ACTIVE

Being active is a third imperative. The essential idea is that the

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therapist acts, reacts, or interacts with the Addict Group as someone who is himself real. Because of his life style and the need for his survival in it, the "junkie" often developes an acute sensitivity and perceptiveness to others which at times borders on paranoia (there is always a kernel of truth in the paranoid persons ideations by the way). He looks to spot quickly the weaknesses, shortcomings and inconsistencies in the therapist. If the therapist cannot be active in his relationship with the addict, cannot react to and interact with group members as one human being to another, and must hide behind his "role" as "therapist" (whatever that means to him), he will quickly be labeled as a "lame" and a "phony" and regarded with contempt by the addict. The addict perceives his own position with the therapist as a lowly one from which there can never be a recovery. He sees the therapist as someone from whom he can never gain respect. At the same time he feels that respect from one who must hide, cannot be real and respect from him is worth nothing.

Being active in group therapy with the addict means interacting on a genuine feeling level. The therapist's responses must be on more than a cognitive level. For example, "I have very bad feelings about what you did, it really made me angry", instead of "I must question whether that was an appropriate thing for you to have done". This also means that there are times when the therapist might, within limits, share with the addict group some personal problem of his own such as being depressed over the loss of a friend or relative, or being upset and aggravated following an argument with his spouse. This kind of sharing not only

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humanizes the relationship, but may create for an excellent opportunity to provide an object lesson for the drug user. This is especially true if the therapist can critically and undefensively evaluate his own behavior and the part he played in the problem he has shared.

RELATIVE

Fourth, therapy must be relative, geared to where the drug user is in the cycle of recovery from drug dependency. It is not a contradiction of what I have previously stated about prohibiting drug use during a course of therapy to now state that during the drug abusers early efforts to "clean up" from drugs, chances are that he will use again. Because of the almost magical and transforming powers that drugs have to the drug dependent person he is almost sure to have at least one and probably repeated relapses. Therapeutic goals with the drug dependent person must be counter-balanced by what one can realistically expect considering the insidiousness of the drug taking compulsion. If the drug taker has been in therapy for a period of 4 months and has remained clean during that time only to suddenly and seemingly without explanation begins to use drugs again, this should not be considered a failure. Rather it should be viewed as regression back to a former and more comfortable method of coping. One might even go so far as to say that progress in therapy with the drug dependent person can be measured by his increased ability to tolerate longer and longer periods of drug abstinence and by shorter periods of time in between of drug usage.

REPAIRATIVE

Fifth, therapy must be repairative. People cannot fundamentally

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grow and change beyond the image they have of themselves as people. This is even more so with the drug dependent person who is labeled as "junkie" by society, but also, he is the first to label other drug abusers as "junkie" and thus himself.

Therapy with the drug dependent person must be repairative in a way that it includes but must also be more than the concept of "a corrective emotional experience" which most therapists describe to mean the relationship aspects of the therapeutic process between patient and therapist. With the drug dependent person, therapy must provide him with something to do, it must offer new experiences far removed from the drug subculture from which he came that will provide him with a new and different way of viewing himself. This might include ongoing experiences in music appreciation, adventures into literature, theatre and drama; film-making and art. It might include such things as camping, hiking, canoeing, mountain climbing, karate, yoga, transcendental meditation or any such experience which will help that person begin to experience life and himself in relation to life in a new and different way. In this sense then, therapy should address itself to the development and building of other roles in life that the person can find meaning and expression in, broadening and expanding his dimensions and relatedness to himself and to others. Therapy should hold out the opportunity for the drug dependent person to be able to optimistically see himself operating in the role of student, husband, father, writer, reader of books, or any combination of hundreds of roles that he can operate in.

It is important to understand that the drug dependent person basically

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sees himself as a damaged person. He has acted out destructively against himself, masochistically abusing his body by sticking needles into his arms and ingesting harmful chemicals and poisons. His mind and his ability to think may be adversely affected, perhaps permanently, not to mention the numerous other ways in which he has ill-treated himself while living the life of a "junkie". Why then should he not see himself as damaged? He is! It is this sense of damage of mind, soul, and body that therapy must seek to heal, nurture, and repair. Therapy must help restore the junkie's integrity and image of himself as a decent, worthwhile human being.

This cannot be done through excessive verbal gymnastics alone, no matter how skilled the therapist or well meaning his intent. The drug dependent person, the addict, the "junkie", as he has experienced his degradation, the road to his salvation must be experiential. He must do! He must be an active participant in the recovery of his own life. As he has seen and suffered his own failures so must he see and feel his own successes and begin to build upon them. But the opportunity to have them must be provided for him through a carefully thought out program of "therapy", i.e. role and skill development in addition to talk therapy. But most importantly, he must be exposed to things and doing things which perhaps were never previously within the realm or context of his knowledge of existence.

One of the problems with many drug programs, and/or therapeutic communities that I personally know about, is that somehow the message is conveyed to the recipients of these programs that they can never be any-

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thing else, "once an addict, always an addict". Many of these programs are devised and designed to keep the addict dependent upon the program and say to him "that it is only through us that you can hope to remain free of drugs". It is unfortunate, for these programs and the people in them that there is an overemphasis on the "bad" and the unhealthy and not enough emphasis on developing the "good", the healthy and the strengths of the people in the program. It seems as if the programs subsist and are subsidized by the recovering addict's constantly kept alive fear that if he ever leaves the program he will surely use drugs again. In fact, many people who do leave the program under these circumstances do use drugs again and often they use on the day of departure! There are a variety of factors which, perhaps explain this condition but that is another discussion. One comment however; it is is curious that most of the people who complete a period of treatment at one of these therapeutic communities often introduce themselves to others (or are introduced by someone else from that program) as an ex-drug addict. They do not say one word more about themselves as human beings. This strongly suggests that even after a period of "treatment", these individual's "claim to fame", their identity, continues to be associated with addiction to drugs.

MANIPULATIVE

Finally, in entering into a therapeutic relationship with the drug dependent individual, the therapist must accept the fact that he himself must be manipulative. This notion probably stirs some uncomfortable, if not outright negative feelings, since many therapists don't like to consider their actions as manipulative. Instead they prefer to think of themselves as helping the patient to "work through" or to "resolve" their conflicts.

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Whatever semantic maze one travels through, when therapist and patient agree to work together in therapy, it is the therapist's skill of playing brinkmanship and remaining "one up" on the patient that counts.

There are obviously negative and positive uses of manipulation in therapy. Historically, manipulation used creatively and in the interest of the patient has been one of the tools of the trade. Some therapist in their work still rely fairly exclusively on manipulation of the environment as an effective means of helping others.

When working with drug abusers the therapist takes a position on the issue of drug abuse and pits his and society's value system against the value system of the drug abuser, based on the conviction that a drug free life is better than drug reliance. Since there is no absolute empirical proof that this belief is true, the therapist is attempting to manipulate the patient into replacing one value system for another. I am convinced that when patients generally initially start to get better they do so in the beginning more out of their need for approval and love from the therapist, and not because they are tired of their neurotic suffering. It is only later after they have realized some satisfaction through the experience of managing their lives differently that they begin to change for themselves.

The drug user presents many difficult problems to the conscientious therapist. Many of the prerequisites to real, human relationships and responsible, satisfying living are difficult to gain access to and must be nurtured in this person.

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I have tried to present what I consider to be a philosophy of psychotherapy to serve as a guideline for therapists working with individuals who abuse drugs. Obviously, there are other considerations in addition to the six imperatives which I have not discussed. For example, working with the drug abuser and his family in Family Therapy must be given top priority. In addition if one considers himself really involved in dealing with the problem of drug abuse, he must be involved in social action, leading to positive social change. Both of these subjects are important topics requiring serious and lengthy discussion under their own headings.

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